



LICENSURE APPLICATION ADDENDUM: FACT SHEET FORM

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES OFFICE OF LICENSURE

INSTRUCTIONS: This form is an addendum to the application for license and is to be used to describe the facility/service to be operated at a given site. One (1) fact sheet form is to be completed for each distinct facility/service category to be operated at a given site. This form must be completed when making application for initial license to operate a newly established facility/service. This form is also to be used by any current licensee who is applying for license to operate an additional facility/service, to relocate a currently licensed facility/service to another site or building, to expand an existing facility/service, or to change the distinct facility/service category or occupancy of a currently licensed facility/service.

1. NAME OF APPLICANT:

2. DATE:

3. PURPOSE OF FACT SHEET: Identify the reason for the completion of this fact sheet: (Check one)

- ☐ Initial application by new applicant for license to operate a newly established facility/service. (A completed "Initial Application for License" form must accompany this fact sheet.)
- ☐ Application by a current licensee for license to operate an additional facility/service to be established by current licensee.
- ☐ Application by a current licensee to relocate a currently licensed facility/service to another site or building. (Licenses are non-transferable.)
- ☐ Application by a current licensee for approval of major renovation; change in use or occupancy; or expansion of the physical plant of a currently licensed facility/service. (A new License may be required.)

4. NAME AND LOCATION OF FACILITY/SERVICE. Identify this facility/service as it is to be named by the applicant, known to the public, and listed on the license:

Name		Facility/Service Telephone No.
Street Address of Facility/Service:		
City / Town:	Zip Code:	County:

5. DISTINCT CATEGORY. Identify the distinct category of this facility/service as defined in the licensure rules: (CHECK ONLY ONE.)

Mental Health

- ☐ Outpatient ☐ Vocational Program
- ☐ Adult Day Treatment Services
- ☐ Adult Residential Treatment Program
- ☐ Crisis Stabilization
- ☐ MH Hospital
- ☐ Supportive Living
- ☐ Mental Health Psychosocial
- ☐ Therapeutic Nursery
- ☐ Intensive Day Treatment for Children & Youth
- ☐ Residential Treatment for Children & Youth
- ☐ Partial Hospitalization Programs
- ☐ **Other.** None of the above categories describe this facility/service. Attach a description of the facility program or services to be provided.

☐ **Personal Support Services**

Mental Retardation

- ☐ Supported Living Services
- ☐ Day Services
- ☐ Early Intervention
- ☐ Diagnosis & Evaluation
- ☐ Residential Habilitation
- ☐ Institutional Habilitation
- ☐ Boarding Home
- ☐ Placement Services
- ☐ Semi-Independent Living
- ☐ Respite Care Services

6. SITE MANAGER/DIRECTOR. Identify the person who is charged with the overall daily management of this facility/service:

Name of Person:	Title/Position:
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Has this person ever been convicted of, or currently under any charges of a felony offense under the law? ☐ NO. ☐ YES.

If yes, attach an explanation of the date, type and place of the charge, court action taken, or current disposition.

NOTE: ITEMS NUMBERED (7) THROUGH (22) DO NOT APPLY TO PERSONAL SUPPORT SERVICES OR MENTAL RETARDATION CATEGORIES OF PLACEMENT SERVICES, SEMI-INDEPENDENT LIVING OR RESPITE CARE SERVICES.

7. NUMBER OF BUILDINGS. Identify the number of buildings on the site of this facility which are to be used for service recipient residences or other service recipient programs: _____. If more than one (1) building is to be used on the site of this facility category, then list each building by its name or location on the site, and give the primary use of each building and the number of service recipients to reside or to be served in each building.

Primary Use of Building

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

(If necessary, attach a separate sheet, and check here ☐.)

8. OWNERSHIP OF PREMISES. Identify the ownership of the buildings, premises or real property in which this facility is to be located:

(Check One.)

☐ Owned by the State of Tennessee

Name: _____

Address: _____

City & State: _____

9. NUMBER OF SERVICE RECIPIENTS. Indicate the number of service recipients to reside or to be served in this facility: _____
Are any of the service recipient six years of age or younger? ☐ NO. ☐ YES.

10. SQUARE FOOTAGE. Total occupiable space of facility in square feet: _____

11. HOURS OF OPERATION. Indicate the normal days and hours of facility's operation: _____

12. SHARED OCCUPANCY. Are other activities or occupancies to occur in this building(s) which are **not** under the control of the licensee/applicant? ☐ NO. ☐ YES. If yes, describe: _____

13. MOBILE, NON-AMBULATORY SERVICE RECIPIENTS. Are mobile, non-ambulatory persons (persons using wheelchairs, walkers, etc.) to be served in this facility? ☐ NO. ☐ YES.
If yes, are these persons capable of transferring unassisted from a bed or other fixed position into the wheelchair or other mobility device and transversing a predefined means of egress from the facility? ☐ NO. ☐ YES.

14. SERVICE RECIPIENT SELF-PRESERVATION. Are all of the persons to be served in this facility to be persons who are capable of self-preservation by responding to an emergency signal, including prompting by voice, and following a pretaught evacuation procedure from the facility? ☐ NO. ☐ YES. Any persons with deafness? ☐ NO. ☐ YES. Any persons with blindness? ☐ NO. ☐ YES.

15. SECURITY MEASURES. Are security measures, such as exit doors or windows locked against client egress, restraints, or seclusion, which are beyond the client's control to be used in this facility? ☐ NO. ☐ YES. If yes, explain: _____

16. VOCATIONAL ACTIVITIES. Are vocational activities to be conducted in this facility? (Activities of an industrial or productive nature such as contract work, assembling, packaging, woodworking, metalworking, painting, stripping, etc.) ☐ NO. ☐ YES.

17. FOOD SERVICE. Are food service, food preparation, and meals to be provided by this facility on a regular basis to the service recipients of the facility? ☐ NO. ☐ YES.

18. BATHROOM ACCOMMODATIONS. Number of separate bathtubs or shower stalls: _____. Number of toilets: _____.
Number of urinals: _____. Number of sinks or hand lavatories in bathrooms: _____.

19. BUILDING CONSTRUCTION. This facility is to be located in: (check one) ☐ A building to be constructed or under construction.
☐ An existing building to be adapted for the facility's use. Number of stories or floors: _____.
Basement: ☐ YES. ☐ NO. Indicate the building's type of construction: ☐ Woodframe with wood, shingle or metal siding.
☐ Woodframe with Brick Veneer. ☐ Masonry Block, no woodframe members. ☐ Masonry Block with woodframe members.
☐ Reinforced concrete with steel members. ☐ Other, describe: _____

NOTE: ITEMS 20 THROUGH 22 ARE TO BE ANSWERED ONLY FOR RESIDENTIAL FACILITIES.

20. LIVE-IN STAFF. Are staff members, proprietors, or family members of the staff or proprietor to reside or have sleeping arrangements in this facility? ☐ YES. ☐ NO. If yes, how many such persons: _____.

21. TOTAL OCCUPANCY. Total number of persons including service recipients, staff, family, etc. (add items 9 and 20 above) to reside in this facility: _____.

22. NUMBER OF ROOMS. Service recipient bedrooms: _____. Staff or other bedrooms: _____. Living Room: _____.
Den: _____. Dining Room: _____. Kitchen: _____. Bathrooms: _____.

23. OTHER. Use this space to provide any additional information or to explain any of the above items.

24. CERTIFICATION OF INFORMATION. The information contained in this fact sheet is an addendum to, or a part of the application for a license. the person signing below must be the individual applicant in the case of a proprietorship or partnership; or the chairperson or equivalent officer of the governing body in the case of a corporation or other association making application; or in the case of a governmental agency or state university, the person charged by the appointing authority with responsibility for the operation of the facility/service.

I HEREBY DECLARE THE INFORMATION CONTAINED IN THIS LICENSURE APPLICATION ADDENDUM TO BE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO CERTIFY THIS INFORMATION IN MAKING APPLICATION FOR LICENSE TO CONDUCT THE FACILITY DESCRIBED HEREIN. I AGREE TO COMPLY WITH THE RULES PROMULGATED FOR THE OPERATION OF THIS FACILITY/SERVICE UNDER TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4.

SIGNATURE OF APPLICANT OR AUTHORIZED AGENT:	DATE:
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TYPE OR PRINT NAME AND TITLE OR POSITION OF PERSON SIGNING ABOVE:

FOR TDMHDD OFFICE USE ONLY—DO NOT WRITE IN SPACE BELOW

LICENSURE REVIEW AND APPROVAL STATUS:

☐ NO LICENSURE GRANTED: Reason:

☐ LICENSURE GRANTED.

License Type:

☐ Initial. ☐ Full. ☐ Provisional.

Effective Date:

Expiration Date:

Service Type:

☐ MH. ☐ MR. ☐ PSS.

Distinct Category:

Life Safety Occupancy Classification:

Approved for Mobile, Non-Ambulatory?

☐ No. ☐ Yes.

Service Recipient / Bed Capacity:

Other Special Conditions Stated on License:

FINAL REVIEW AND APPROVAL STATUS COMPLETED BY: